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ABSTRACT

This article addresses issues of chemical dependency treatment of individuals who are deaf or hard of hearing and reports on specialized treatment approaches developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. This population faces special barriers to treatment and recovery including lack of recognition of a problem within the community; confidentiality issues; lack of substance abuse resources for deaf/hard of hearing people; enabling on the part of family, friends and professionals; funding concerns; and lack of support for ongoing recovery. Issues related to communication affect deaf and hard of hearing persons along the substance abuse services continuum. The Minnesota program's specialized treatment approaches are designed to accommodate the communication and cultural needs of clients. Based on the Twelve Steps of Alcoholics Anonymous, the program features the use of drawing, role play, education, and American Sign Language and other appropriate communication systems. Discussion examines the program's treatment philosophy, purpose statements, and expected outcomes. Also covered are behavior management philosophy and techniques, aftercare considerations, and information about treating mentally ill clients who are chemically dependent. Appendices provide sample client assignments. (Contains 13 references.) (DB)

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Chemical Dependency Treatment: Specialized Approaches for Deaf and Hard of Hearing Clients

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Abstract

Accessing chemical dependency treatment and beginning a program of recovery presents many problems for any individual, but those who are chemically dependent and deaf or hard of hearing face additional barriers to treatment and recovery. Barriers may include lack of recognition or a problem within the community; confidentiality issues; lack of substance abuse resources for deaf/hard of hearing people; enabling on the part of family, friends and professionals; funding concerns; and lack of support for ongoing recovery. Issues related to communication impact deaf and hard of hearing persons along the substance abuse services continuum. Specialized treatment approaches developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals help to accommodate the communication and cultural needs of clients. Based on the Twelve Steps of Alcoholics Anonymous, the Program approaches feature the use of drawing, role play, education and American Sign Language and other appropriate communication systems. The article includes examples of treatment assignments, philosophy, purpose statements and expected outcomes. Also covered are behavior management philosophy and techniques, aftercare considerations, and information about treating mentally ill clients who are chemically dependent.

Chemical Dependency Treatment: Specialized Approaches for Use with Deaf and Hard of Hearing Clients

Introduction

Getting treatment and beginning a program of recovery presents many problems for any individual, but those who are chemically dependent and deaf or hard of hearing face additional barriers to treatment and recovery. At the present time, little data is available to describe the extent of the substance abuse problem with deaf and hard of hearing young people or adults. The majority of the research indicates that deaf and hard of hearing people face at least the same risk of alcoholism and drug abuse as do hearing people (Lane, 1985). Dennis Moore (1991) also points to what he terms "the paucity" of epidemiological data related to the prevalence of substance abuse in the Deaf Community. To date, there have only been two residential school for the deaf studies (Boros, 1981; Isaacs, Buckley & Martin, 1979, Johnson and Lock, 1981) and one state wide study estimating the incidence of substance abuse in the young deaf population.

Barriers to Treatment Services

In addition to the problems of insufficient data to describe the dimensions of the drug abuse problem among deaf and hard of hearing persons, typical treatment and recovery resources pose barriers to these individuals. Deaf and hard of hearing people have unique needs which are often not adequately addressed in a non-specialized substance abuse treatment program because of inadequate accessibility (Rendon, 1992, Whitehouse, Sherman & Kozlowski, 1991; Lane, 1985). The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals has identified the following barriers to treatment and recovery for persons who are deaf or hard of

hearing.

1. Recognition of a problem - There is a general lack of awareness of the problem of substance abuse within the Deaf Community. This situation is influenced by a lack of appropriate education/prevention curricula and limited access to recent widespread efforts to educate people about alcohol and other drugs through the mass media.

2. Confidentiality - Traditionally, the Deaf Community has communicated information about its members very efficiently through person to person contacts. This grapevine-line system of communication within the Deaf Community has kept deaf people informed of community news and concerns. But, individuals in treatment often fear that their treatment experience will become a part of the grapevine information and are therefore reluctant to share their story.

3. Lack of Resources - Few resources along the continuum of substance abuse services exist that meet the communication and other cultural needs of deaf and hard of hearing persons. Historically, the array of treatment services available to hearing individuals has not been accessible for deaf and hard of hearing people. There is also a lack of qualified professionals trained in the areas of substance abuse and deafness. Deaf and hard of hearing individuals, their families or professionals serving them may struggle for lengthy periods of time attempting to locate and access appropriate programming.

4. Enabling - The tendency of family members, friends and even professionals to take care of and protect individuals who are "disabled" or "handicapped" is often played out with deaf and hard of hearing persons. The addition of substance abuse only exacerbates this problem. Often this results in the deaf or hard of hearing individual not being held accountable for his/her behavior. Enabling also sends the unintended message that the deaf or hard of hearing person is

not able to take care of him/herself.

5. Funding Concerns - Specialized programming to meet the needs of deaf and hard of hearing persons is costly due to the need for specially trained staff, travel costs and the depth and breadth of the client's needs. The process of accessing funding sources may act as a barrier itself to deaf and hard of hearing persons. It is not uncommon for funding agencies to require a number of assessments with various professionals in order for funding to be approved. Again the shortage of appropriately trained professionals in these various fields impacts the accessibility of prerequisite services.

6. Lack of Support in Recovery - Disengaging from old friends may be especially difficult for people who are deaf. Small numbers of deaf peodple within the community, many of whom use mood altering chemicals leave the recovering person with few socializing opportunities. The relatively small number of recovering deaf role models also results in a lack of a sense of support. Also, until recently, alcoholism or drug addiction was often viewed as a moral weakness instead of a chronic disease sometimes contributing to the ostracizing of dependent individuals from the Community.

Communication

In order to access treatment services, the deaf or hard of hearing person must be able to access communication of the treatment process. For many, accessing spoken and written language is a struggle. Concern about accessibility problems related to communication that deaf and hard of hearing people face in entering most treatment programs have been repeatedly documented (Berman, 1990; Lane, 1985; Miller, 1990). It has been found that treatment

programs in Illinois, for example, were only minimally compliant in meeting the federal legal mandates as far as accessibility for disabled persons (Whitehouse, Sherman, Kozlowski, 1991). Similar situations exist in most other states.

For any person who is deaf, communication is a crucial issue. Most deaf people depend on American Sign Language (ASL), a visual language, to communicate (Stokoe, 1981). Because they do not hear language and learn it as hearing children do, they often struggle with English language--written and verbal. Traditional treatment approaches often emphasize the use of reading/writing tasks and "talk therapy" and thus make it difficult for anyone who has language difficulties. Hard of hearing persons face a different set of barriers related to communication in treatment including poor acoustical environment, inadequate lighting, or inability to follow a conversation in a group (Ancelin, 1992).

Communication difficulties also mean that many deaf and hard of hearing persons have had less access to educational information about alcohol and other drugs than their hearing peers. School education/prevention programs and media information often preclude access by deaf people for a variety of reasons including the lack of captioned or signed materials, use of unfamiliar vocabulary and other communication related issues. Often, deaf people receive little or no information about drugs and alcohol or misunderstand the information presented in the media. Historically, few residential (state) schools and almost no mainstream public school programs involve deaf students in substance abuse curricula (McCrone, 1982).

Some treatment programs have attempted to resolve the communication issue by using a sign language interpreter and integrating deaf clients into the regular treatment process. Although this is successful for some individuals, many deaf people do not experience treatment in an

effective way in this setting. Often, the interpreter is provided only for formal programming and the deaf person misses out on communication with other patients at various times during the day or evening such as free time or meal time. In many instances, there is a shortage of available interpreters so communication is not provided to the client. Deaf and hard of hearing individuals in treatment need more than just interpreting services. It is essential that a full array of services such as education from a qualified teacher of deaf students, direct communication with clinical staff, captioned or sign video material or innovative treatment approaches be provided. Sometimes, the deaf person is unable or unwilling to establish a bond with treatment staff and patients who do not understand what it means to be deaf or know how to communicate in ASL. For many deaf individuals, this experience could be equated to a hearing individual being placed in a treatment program where Spanish is spoken and an English interpreter is brought in for several hours a day. The difficulty of developing meaningful relationships without fluent communication seems clear.

Lack of awareness or understanding of deaf culture on the part of treatment staff or peers can also add to difficulties in a non-specialized program. For example, the experiences of socializing with deaf peers is cherished in Deaf Culture. However, for a deaf person attempting to recover from chemical dependency, socializing with deaf peers can be problematic when the number may be small and many are using or abusing alcohol and other drugs. Letting go of using friends may mean leaving the Deaf Community, at least for a period of time. While still recommending separation from peers who are using, treatment staff who are knowledgeable about Deaf Culture can appreciate the special difficulty this presents when it leaves the person with few deaf friends, or none at all. The Deaf Club, which serves as the central gathering and socializing

place for deaf people, is often supported by the sale of alcohol. Attitudes toward alcohol in the Deaf Community are also important to understand. For example, a study of the attitudes of deaf high school students toward alcohol shows their perception of drunkenness as a "sin" or a sign of character weakness (Sabin, 1988). Understanding of these dynamics is essential on the part of treatment staff. Further, because deafness is considered a low incidence population, deaf people are often geographically isolated from one another. Ninety percent of all deaf people are born to hearing parents and are often the only deaf person in the family. As a result, "Deaf Schools" (state run residential schools for deaf children) become the cultural center and the place where children learn ASL and traditions of the Deaf Community (Padden, 1980).

The following quote sums up the difficulties deaf and hard of hearing persons face once alcohol or other drug problems are identified.

> "Large numbers of deaf alcoholics have been forced to struggle without the help of community agencies. Even within the alcoholism agencies, barriers to treatment exist because the programs have been designed for verbal, hearing clients. Counselors do not understand the psychosocial aspects of deafness or the specific forms of denial that occur, and they do not possess manual communication skills. Agency budgets do not traditionally include funds for sign language interpreters....It is the encounter with confusion and ambivalence found in these situations that have caused deaf alcoholics to avoid agencies, increasing their frustration (and their denial) about being different" (Rendon, 1992).

A Model Program

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI) is a specialized program designed to meet the communication and cultural needs of deaf and hard of hearing persons in chemical dependency treatment. The Program is the recipient of a critical populations grant from the Center for Substance Abuse Treatment

(previously the Office for Treatment Improvement). The Program was awarded the initial grant funds in September, 1990, and was awarded two additional years of continuation funds in September, 1993. The grant funds enable Program staff to provide outreach and training, to modify and develop materials as well as to provide treatment to deaf and hard of hearing persons.

The MCDPDHHI is comprised of a highly trained staff who provide a full range of treatment services. The treatment team includes a medical director, a program director, certified chemical dependency counselors, interpreters, an outreach counselor, a family counselor, a licensed teacher of the deaf, a chaplain, an occupational therapist, a recreational therapist, nurses, a case manger, unit assistants and a program secretary. Staff are fluent in sign language as well as knowledgeable about and sensitive to Deaf Culture. Program offerings include individual and group therapy, school programming, lectures, occupational therapy, spirituality group, recreational therapy, grief group, men's/women's groups, participation in Twelve Step groups, comprehensive assessment services and aftercare planning. As a part of a major metropolitan medical center, the Program also offers a full range of physical and mental health services.

The Program operates on a Twelve Step philosophy and offers patients the opportunity to attend Alcoholics Anonymous, Narcotics Anonymous or other Twelve Step meetings within the hospital as well as in the community. Some meetings are interpreted for deaf people; others consist of all deaf members. Treatment approaches are modified to respect the linguistic and cultural needs of the patients. For example, patients are encouraged to use drawing, role play and communication in sign langauge as opposed to written work to complete Step assignments. Written materials used in the Program are modified and video materials are presented with sign, voice and captions. TTY's (which allow deaf people to communicate on the phone), assistive

listening devices and decoders for the television are among the special equipment provided for patients. A Clinical Approaches Manual has been developed by the Program. This manual describes treatment approaches, philosophy, task rationale, step assignments and educational topics used with deaf and hard of hearing clients in treatment. This manual is intended to assist other service providers who want to replicate the Minnesota Program. Information from the manual is shared in later sections of this paper.

Program staff give top priority to viewing each client as unique and strive to meet treatment needs in an individualized, therapeutic manner. Attention is given to client diversity with respect to ethnic background, education, socialization, cultural identity, family history and mental health status. In addition, staff members recognize variation in deaf and hard of hearing clients in their degree of hearing loss, their functioning ability, their communication preferences and their drug use experiences. These factors corroborate the benefits of a flexible approach. The Program recognizes the importance of all clinical staff being knowledgeable about a variety of communication methods and being fluent in American Sign Language. Effective communication is viewed as the most essential tool in providing quality treatment services.

Phases of Treatment--Phase I, Evaluation

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals encompasses three phases. Phase I is the evaluation phase of the program. During Phase I, various assessments are used to gain an understanding of the individual client and his/her use of mood altering chemicals. Typically, assessments include medical background, social history, chemical use history, a clinical assessment and a communication assessment. The communication

assessment is an important tool which profiles a client's communication preferences and needs. The results of this assessment allow treatment staff to present information and provide support using the client's own preferred method of communication. During Phase I, clients also complete a drug chart assignment in which they detail the different drugs they have used, a description of their last use and examples of consequences of their use in major life areas such as physical health, legal, family, social, work/school and financial. With few exceptions, drug chart work, and many other assignments are done through drawing. The use of drawing removes the barrier created for many deaf and hard of hearing people by the English language. It also seems to encourage the client to be more in touch with his/her experiences and thus, more in touch with the feelings connected to those experiences. The following rationale is the basis for various tasks included in the Drug Chart.

TASK	OUTCOME
Drugs used/last time used	Client recognizes the extent (in time and quantity) of his/her use of mood altering chemicals.
Consequences	Client recognizes the extent to which the use of chemicals has negatively impacted his/her life. Understanding the relationship between use and consequences is especially valuable.
Total Assignment	Client evaluates the evidence--or lack of evidence--for a diagnosis of chemical dependency and gains a more realistic perspective of his/her use.

A copy of a sample drug chart assignment can be found in Appendix I of this paper. When the client has completed the drug chart assignment, he/she is asked to present the work in a

group of peers. Peers and staff provide feedback for the client. Upon completion of Phase I, appropriate clients (those diagnosed as chemically dependent using DSM IV criteria) are referred to Phase II, treatment.

Phase II--Primary Treatment

Phase II is the primary treatment phase in which clients receive education about the Twelve Steps and complete Step work assignments. Ideally, clients will complete Steps One through Five while in primary treatment. However, the emphasis is for clients to integrate the concepts of the Steps into their recovery as opposed to completing the assignments. Step work assignments are modified to meet the needs of the individual client, completed by clients (often through drawing of pictures) and presented in therapeutic groups with staff and peers. Most often, clients present their work using American Sign Language. Task rationale for various portions of step assignments help to identify the objectives of each assignment and help to determine if the client has met the objective.

The goal of Step One is to help individuals identify the aspects of powerlessness and unmanageability in their lives and to get in touch with their feelings. Giving examples of how their use of alcohol or other drugs has hurt others as well as themselves help to personalize the powerlessness and unmanageability of their own addiction. It is also during Step One that a client confronts his/her denial. Following the Alcoholics Anonymous philosophy, the client is asked to admit that drugs/alcohol are more powerful than they are, and that they cannot manage their lives any more. This helps to establish a foundation on which to build a sober life through the subsequent steps. The task rationale is stated as follows:

TASK	OUTCOME
Picturers of unmanageable	Client identifies aspects of his/her life that are unmanageable related to the use of alcohol and other drugs.
Pictures of powerlessness	Client identifies examples of loss of control over alcohol and other drug use.
Pictures of feelings (related to powerless and unmanageable)	Client explores and expresses feelings related to the powerlessness and unmanageability in his/her life.
Pictures of hurting self and others	Client identifies how his/her use has hurt or caused dysfunction with self and others. Client recognizes impact of his/her use.

A typical Step One (see Appendix II) helps the client to understand the significance of the problem with alcohol and drugs. Again, much of the work is done through the medium of drawing and presented in the client's preferred mode of communication to a group of peers and staff. After the work has been presented, self-related feedback from peers helps the client develop a sense that he/she is not alone, that others have had similar experiences. The client's work is accepted when he/she is able to demonstrate an understanding of the concepts of unmanageability, powerlessness and the effects on self and others. For clients who have not completely understood the concepts, additional assignment(s) may be given to help supply the missing information or understanding. Most of the Step One assignments are very similar in the tasks given to clients. Typical modifications of this assignment would involve breaking the assignment down into smaller parts, limiting the scope of the assignment to a period of relapse or expecting a lesser number of examples in each task.

Step Two assignments (as well as assignments for the subsequent steps) tend to be more individualized for each client. A sample Step Two assignment may be found in Appendix III of this paper. With the exception of receiving the Step prep and viewing the ASL video about the Step, the assignment is developed by the staff team to meet the individual needs of the client. A list of potential tasks (contained in the Clinical Approaches Manual) provides options for creating the assignment. Again, clients complete the assignment and present it in group, as previously described. The goal of the Step Two assignment is to allow clients to develop a sense of hope. The assignment helps the client realize that he/she is not alone, that there is a power to sustain him/her in recovery. Since many clients often have had negative or confusing experiences with the concept of God/religion, they are encouraged in Step Two to identify their own Higher power as someone or something--not necessarily God--which they believe to be greater than themselves. Many clients identify their sponsors or an AA/NA group as their Higher Power. Asking for and accepting help are vital parts of acknowledging and accepting a Higher Power. Task rationale for this step are as follows:

TASK	OUTCOMES
Identifying people who can help, places that feel safe, times when help is needed, and places & people to avoid.	Client recognizes and utilizes sources of support to stay sober and identify those people and places which threaten their sobriety.
Picture of how it feels to ask for help or keeping a feelings journal.	Client recognizes and accepts feelings associated with asking for help.
Identifying people the client can trust and places for support.	Client identifies people and places that can be trusted to help support sobriety.

Step Three is individualized in the same manner as described above for Step Two. In this Step, the emphasis is on action--safe places the clients can go for sober support, people who can help the client stay sober, and so on. In this step, clients are also asked to begin developing their understanding of Higher Power. The Serenity Prayer (below) is often used as part of the assigned work of Step Three. In the treatment setting, it is used to close each therapeutic group session. Clients are encouraged to use the Serenity Prayer as a tool for coping with everyday stresses of living as well as with efforts to maintain sobriety.

The Serenity Prayer
God, grant me the serenity
to accept the things I cannot change,
the courage to change the things I can
and the wisdom to know the difference.

As with Step Two, the Clinical Approaches Manual presents a number of tasks which may be used in creating a Step Three assignment. A sample Step Three is included in Appendix IV. Task rationale includes the following:

TASK	OUTCOMES
Explaining/describing Higher Power	Client begins to understand who/what his/her Higher Power is.
Explaining "my will" and my Higher Power's will.	Client begins to differentiate between wants and needs; between their own will and the will of Higher Power.
Explaining communication with Higher Power	Client discovers how to seek help from Higher Power.

The Clinical Approaches Manual goes on to describe philosophy, task rationale and

assignments for each of the steps through Step Twelve as well as other information about the approaches and assignments used at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. The manual also includes examples of client work. A sampling of other sections of the manual, a Behavior Contract, and Family Week Assignment is included in Appendices V and VI.

In addition to step work and group/individual counseling, clients are educated and supported through lectures, educational programs and other activities mentioned above. While chemical dependency is the primary area of concern, additional problem areas, such as ineffective coping skills and grief/loss issues, receive attention in programming. Throughout the treatment stay, clients are provided with education related to health concerns commonly associated with substance abuse. Educational lecture topics include HIV/AIDS, sexually transmitted diseases, physical effects of mood altering chemicals, birth control and various types of abuse. Medical testing and consultation is available to all clients.

Beginning in Phase I and continuing throughout the client's stay, involvement in Twelve Step meetings is provided as well as education about the programs of Alcoholics Anonymous, Narcotics Anonymous and other Twelve Step groups. A family week experience is provided for clients and their families as appropriate whenever possible. Often, family members are not fluent in sign language and for the first time, through the use of an interpreter, the family explores a variety of issues. If family members are unable to attend, materials and phone contact with staff is available to all family members. An educational component helps school aged clients maintain their schooling while in treatment. The Program staff includes a licensed teacher of deaf and hard of hearing students.

Phase III includes an optional extended care program for those clients who need additional support in transitioning back into the community and an aftercare component. For clients who come from other states, staff members attempt to set up a comprehensive aftercare program in the client's home area, offering education and support to service providers there. For local clients, the Program offers individual aftercare sessions as well as an aftercare group and connects clients to other local resources such as Twelve Step meetings, a Relapse Prevention group, therapists fluent in American Sign Language, an interpreter referral center, vocational assistance, halfway houses, sober houses and other sources of assistance and support. Networking with other service providers both locally and nationally is an important activity related to aftercare. Aftercare for clients residing in states other than Minnesota continues to be a challenge. There are limited Twelve Step meetings that currently provide interpreters in major metropolitan areas, let alone rural communities. Shortages of professionals trained to work in this area exist on a national basis. Developing an aftercare plan for out of state clients might be compared to putting together a puzzle--sometimes with many of the pieces missing.

The MCDPDHHI has developed a Clinical Approaches Manual which describes the philosophy and application of the specialized approaches developed in five and one half years of providing substance abuse treatment services to deaf and hard of hearing persons. The philosophy is based on the Twelve Step program of Alcoholics Anonymous. The manual includes instructions for Step work, assignment sheets, examples of client work, behavior management practices, and all other aspects of the Program. Within the approaches developed by the Program, the principles and concepts of the Twelve Steps are taught and reinforced in a way that has been accessible for deaf and hard of hearing clients. A videotape explaining each of the Twelve Steps

in American Sign Language (with voice and captions) accompanies the Manual. In the approaches described, clients come to recognize that they are powerless over alcohol and/or other drugs and that their drug use has caused their lives to become unmanageable. Each client explores for him/herself what the impact of that use has been. Upon reaching an understanding of these concepts of powerless and unmanageability, clients are assisted in seeing that there is hope for changing their lives and resources for doing so. Through the Program, clients acquire information and skills to make different choices in their lives, including the choice of sobriety. The use of the Twelve Step approach helps to prepare clients to access the most readily available source of support in the form of Alcoholics Anonymous groups.

The Program also has developed a number of other specialized materials including Choices curriculum (which provides instruction in decision making and choices); Relapse Prevention Manual; and a prevention videotape entitled "Dreams of Denial". These materials begin to address some of the gaps in the continuum of substance abuse services in the areas of prevention and aftercare.

The MCDPDHHI offers comprehensive outreach and training services to schools, communities and professionals in all aspects of substance abuse from prevention/education through treatment and aftercare. In addition, a grant from the Office of Special Education and Rehabilitation Services allows the Program to sponsor quarterly intensive trainings which cover assessment, treatment approaches, dual diagnosis, family issues and other topics. Professionals in education, treatment and rehabilitation come from around the country to attend these trainings. Staff members are available to meet with deaf and hard of hearing school students on a one time or ongoing basis. School services include prevention programs such as D.A.R.E. (Drug Abuse

Resistance Education) specially modified for deaf and hard of hearing students, educational groups for students at risk, drug/alcohol awareness activities and consultation with school staff, and individual student assessment.

References

Boros, A. (1981). Activating solutions to alcoholism among the hearing impaired. In A. J. Schecter, (Ed.), Drug Dependence and Alcoholism: Social and Behavioral Issues. New York: Plenum Press.

Berman, H. (1990). Chemical dependency assessment in a deaf population. Proceedings of the Substance Abuse and Recovery: Empowerment of Deaf Persons (pp. 37-53). Washington, D.C.: College for Continuing Education, Gallaudet University.

Isaacs, M., Buckley, G., & Martin, D. (1979). Patterns of drinking among the Deaf. American Journal of Drug and Alcohol Abuse. 6(4), 463-476.

Johnson, S., & Lock, R. (1981). A descriptive study of drug use among the hearing impaired in a senior high school for the hearing impaired. Drug Dependency and Alcoholism: Social and Behavioral Issues. Schecter, E. J. (Ed.) .

Lane, K. E. (1985, April). Substance abuse among the deaf population: An overview of current strategies, programs and barriers to recovery. Journal of American Deafness and Rehabilitation Association. 22(4), 79-85.

McCrone, W. P. (1982). Serving the deaf substance abuser. Journal of Psychoactive Drugs. 14(3), 199-203.

Moore, D. (1991). Substance misuse: A review. The International Journal of the Addictions. 26(1), 65-90.

Miller, B. G. (1990, May/June). Empowerment: Treatment approaches for the deaf and chemically dependent. The Counselor. 24-36.

Padden, C. (1980). The Deaf Community and the culture of deaf people. In C. Baker & R. Battison (Eds.), Sign Language and the Deaf Community. Linstok Press, Silver Spring, MD. (pp. 89-103).

Rendon, M. E. (1992). Deaf Culture and alcohol and substance abuse. Journal of Substance Abuse Treatment, 9, 103-110.

Sabin, M. O. Responses of deaf high school students to an attitudes toward alcohol scale: A national survey. American Annals of the Deaf, 133(3), 199-203.

Stokoe, W., & Battison, R. (1991). Sign language, mental health and satisfactory interaction. In Stein, L., Minder, E. & Jabeley (Eds.). Deafness and Mental Health. Grune & Stratton, New York.

Whitehouse, A., Sherman, R., & Kozlowski, K. (1991). The needs of deaf substance abusers in Illinois. American Journal of Drug and Alcohol Abuse, 17(1), 103-113.

Appendix I

Drug Chart Sample

Step Two Assignment

SAMPLE

Step Two tells us: Came to believe that a Power greater than ourselves could restore us to sanity.

Do work in the order written. Get staff to sign before doing the next part.

	Staff Initials/Date
1. Meet with the Chaplain for Step Two prep.	_____
2. Watch ASL videotape on Step Two.	_____
3. Draw 10 pictures of time people helped you.	_____
4. Tell 15 ways you are similar to your peers in treatment.	_____
5. Draw 10 places you can go to get support in recovery.	_____
6. List 10 people who can help you stay sober.	_____
7. Tell 15 things you like about yourself.	_____
8. 2 1:1's with peers	_____
9. 2 1:1 with staff	_____

Present Step Two in group.

Step Two is due on October 3

Appendix IV

Step Three Sample Assignment

Family Week Assignment

Please complete this assignment before Family Week starts. Bring your work with you to all family groups.

What secrets related to using alcohol and drugs do you need to tell your family?

What behaviors do you use with your family to get what you want. Be specific.

What feelings do you have about your deafness that you have not talked about with your family?

What feelings about your deafness do you cover up by using alcohol or other drugs?